HealthComp
Third Party Administrators

Dental Claim Form

Check one:

☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

PATIENT COVERAGE

1. Patient Name First MI Last	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other_____	3. Sex ☐ male ☐ female	4. Patient birth date MM DD YYYY	5. If full-time student School City

6. Employee /subscriber name and mailing address	7. Employee Soc. sec. or I.D. number	8. Employee birthdate MM DD YYYY	9. Employer name an address	10. Group number

11. Is patient covered by another dental plan? ☐ yes ☐ no If yes complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ no	12-a Name and address of carrier(s)	12-b Group no(s)	13. Name and address of other employer(s)

14.-a Employee bane (if different than patient's)	14-b Employee Soc. sec. or I.D. number	14-c Employee birthdate MM DD YYYY	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____ _____
Signed (Patient or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise parable to me directly to the below named dental entity.

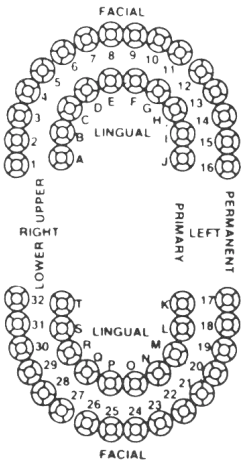
_____ _____
Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Address where payment should be remitted	25. Is treatment result of auto accident?			
City State Zip	26. Other accident?			

18.	19.	20.	27. If prosthesis, is this initial placement?			(If no, reason for replacement)	28. Date of prior placement

21. First visit date current series	22. Place of treatment Office Hosp ECF Other	23. Radiographs or models enclosed?	No	Yes	How many?	29. Is treatment for orthodontics?			If services already Commenced	Date appliances placed	Mos. treatment remaining enter



30. Examination and treatment plan – List in order from tooth no 1 through tooth no 32 – Use charting system shown

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.)	Date of Service Performed Mo Day Year	Procedure Number		Fee	For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

_____ _____ _____
Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA 93718-5018 (800) 442-7247